ATTACHMENT 8a

HEALTH INSURANCE CLAIM FORM

1 MEDICARE [ ] (Medicare #) MEDICAID [P] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A

3 PATIENT'S BIRTH DATE MM DD YY: 01 12 82 SEX M [X] F [ ]

4 INSURED'S NAME (Last Name, First Name, Middle Initial):

5 PATIENT'S ADDRESS (No., Street): 609 Willow

6 PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7 INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8 PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10 IS PATIENT'S CONDITION RELATED TO:

11 INSURED'S POLICY GROUP OR FECA NUMBER:

a OTHER INSURED'S POLICY OR GROUP NUMBER:

a EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b EMPLOYER'S NAME OR SCHOOL NAME:

c EMPLOYER'S NAME OR SCHOOL NAME:

c OTHER ACCIDENT? YES [ ] NO [ ]

c INSURANCE PLAN NAME OR PROGRAM NAME:

d INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE:

d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: DATE:

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY:

15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY:

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring MD

17a I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19 RESERVED FOR LOCAL USE:

20 OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1 313.81 3 2 4

22 MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO:

23 PRIOR AUTHORIZATION NUMBER: 1234567

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 16 92		4	1	W7027		1	XXX XX	2	H			11223344
2 03 16 92		4	1	W7028		1	XX XX	2	H			11223344
3 03 18 92		4	1	W7028		1	XX XX	1	H			11223344
4 03 20 92		4	1	W7028		1	XX XX	1	H			11223344
5 03 16 92		0	1	W7029		1	XX XX	.5	H			11223344
6 03 16 92		0	1	W7030		1	XX XX	.5	H			11223344

25 FEDERAL TAX I.D. NUMBER: SSN [ ] EIN [ ]

26 PATIENT'S ACCOUNT NO: 1234JED

27 ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28 TOTAL CHARGE: $ XXX XX

29 AMOUNT PAID: $

30 BALANCE DUE: $ XXX XX

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized

SIGNED MMDDYY DATE

32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

In-Home Treatment Provider
1 W. Williams
Anytown, WI 55555

PIN# GRP# 87654321

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8 86) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (U2) (12-90) FORM OWCP-1500 FORM RRB-1500